Welcome Form

Welcome to . Thank you for choosing us for your eyecare and eyewear needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

O Mr. O Miss O Mrs. O Ms.

First Name MI Last Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - include area code Work Phone

Email Address Spouse or Parent(s) Name

Person Financially Responsible, If Different than Above

Name Phone

Address Social Security Number

Address (cont.) Birthdate

Place & Address of Employment

Work Phone

ft in cm/m lbs kg

Height Weight

Race

O American Indian Or Alaska Native
O Asian
O Black Or African American
O Hispanic or Latino
O Native Hawaiian Or Other Pacific Islander
O White
O Declined To Specify
O Other Race

Ethnicity

O Hispanic or Latino O Not Hispanic or Latino O Declined To

Preferred Language

O English O Chinese O Dutch/Flemis O French O Germa O Hindi O Indo

How were you referred to our office?

O Phone Book O School O Advertisement O Patient (Please Name)
O Insurance Listing O Drive By O Other O Doctor (Please Name)

PATIENT HAS RECEIVED HIPPA PRIVACY POLICY? O Yes O No Date
Notes

VALLEY VISION
CLINIC LTD.
EXCELLENCE, EXPERIENCE, COMPLETE CARE!

Welcome Form

Name

Primary Insurance Information

Name and Address of Primary Insurance Company | City | State | Zip

O M O F O Other (please specify)

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

O Self O Spouse O Child O Other

Patient Status

O Single O Married O Other
O Full Time Student O Part Time Student O Employed

Secondary Insurance Information

Name and Address of Secondary Insurance Company | City | State | Zip

O M O F O Other (please specify)

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

O Self O Spouse O Child O Other

PLEASE READ:

We require that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from an insurance company is to be paid directly to the subscriber. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature | Date